KANSAS DENTAL BOARD
Landon State Office Building
900 SW Jackson, Room 564-S
Topeka Kansas 66612
Phone 785-296-6400
Fax 785-296-3116

INSTRUCTIONS

To file a complaint, please state clearly and specifically, all allegations against the person named below. **List each incident, specific date(s), full name of the patient, and a brief statement describing each incident.** If additional space is required, please attach additional pages. Attach copies of any documents you have concerning the allegation. In order for the board to fully investigate, both sides of the form must be completed. *****PLEASE ATTACH ANY ADDITIONAL INFORMATION YOU FEEL IS NECESSARY.**

PLEASE TYPE OR PRINT

PERSON MAKING ALLEGATION: NAME_____

ADDRESS_____
Street City State Zip

HOME PHONE_____**DAY TIME PHONE**_____

PATIENT NAME _____ **DATE OF BIRTH**_____

PERSON AGAINST WHOM THE ALLEGATION IS MADE:

NAME_____
(Indicate Profession – Dentist or Dental Hygienist)

ADDRESS_____
Street City State Zip

I agree to testify in any hearings, which may arise as a result of this allegation. The statements I have made are true and correct to the best of my knowledge and belief.

DATE _____ **SIGNATURE**_____

RELEASE OF INFORMATION AUTHORIZATION

I hereby authorize all dentist offices, hospitals, institutions, physicians, clinics, employers (past and present), laboratories, insurance companies, and/or all government agencies to release to the Kansas Dental Board or its representatives any and all information, records, files or documents in any form pertaining to _____ in their possession or control.
(patient name)
The Board in place of the original may use a photo static copy of this release. This release shall expire one year from the date below.

_____
Type or Print Patient Name

_____ _____
Patient Signature **Parent/Guardian Signature (if applicable)**

_____ _____
Date **Date**

****

BOARD USE ONLY- DO NOT WRITE BELOW THIS LINE

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TO_____

ADDRESS_____

CITY, STATE, ZIP_____

Please submit copies of all records indicated below regarding the above release of information authorization. Thank you.

_____Fact sheet
_____ Consultation
_____ X-ray reports
_____ Laboratory reports
_____Notes of dentists, dental hygienists, professional and practical nurses and nurse anesthetists

_____ All dental records
_____ History
_____ Progress notes
_____ Dentist orders

Other_____
_____

Send information to:

Kansas Dental Board
900 SW Jackson, Room 564-S
Topeka Kansas 66612